

# State Medical Society of Wisconsin Statement on the Use of Opioids for the Treatment of Chronic Pain

*Adapted from a consensus statement from the American Academy of Pain Medicine  
and the American Pain Society*

## **I. The management of pain is becoming a higher priority in Wisconsin.**

In the last several years, health-policymakers, health professionals, regulators and the public have become increasingly interested in the provision of better pain therapies. This is evidenced, in part, by the US Department of Health and Human Services' dissemination of Clinical Practice Guidelines for the management of acute pain and cancer pain. These publications state that opioids, sometimes called "narcotic analgesics," are an essential part of a pain management plan. There is currently no nationally accepted consensus for the treatment of chronic pain not due to cancer, yet the economic and social costs of chronic pain are substantial, with estimates ranging in the tens of billions of dollars annually.

## **II. Pain is often managed inadequately, despite the ready availability of safe and effective treatments.**

Many strategies and options exist to treat chronic noncancer pain.

---

*Editor's Note: Appendix II— Pain Management Questionnaire can be found on the SMS website at <http://www.wismed.org/education/question.html>, or for a paper copy contact Terri Weaver at the SMS, 800.362.9080.*

Since chronic pain is not a single entity but may have myriad causes and perpetuating factors, these strategies and options vary from behavioral methods and rehabilitation approaches to the use of a number of different medications, including opioids.

Pain is one of the most common reasons people consult a physician, yet it is frequently inadequately treated, leading to enormous social cost in the form of lost productivity, needless suffering, and excessive health care expenditures.

Impediments to the use of opioids include concerns about addiction, respiratory depression and other side effects, tolerance, diversion, reluctance of patients and family, and fear of regulatory action. **This statement should not be misconstrued as advocating the imprudent use of opioids.** Rather, if a practitioner decides to treat chronic pain with opioids, this document should serve as a guide for both the practitioner and regulators with regard to the judicious use of these drugs in the course of medical practice.

## **III. Current information and experience suggest that many commonly held assumptions need modification.**

**A. Addiction:** Misunderstanding of addiction and mislabeling of patients as addicts result in

unnecessary withholding of opioid medications. Addiction is a compulsive disorder in which an individual becomes preoccupied with obtaining and using a substance, the continued use of which results in a decreased quality of life. Studies indicate that the de novo development of addiction when opioids are used for the relief of pain is low. Furthermore, experience has shown that known addicts can benefit from the carefully supervised, judicious use of opioids for the treatment of pain due to cancer, surgery, or recurrent painful illnesses such as sickle cell disease.

**B. Respiratory depression and other side effects:** Fear of inducing respiratory depression is often cited as a factor that limits the use of opioids in pain management. It is now accepted by practitioners of the specialty of pain medicine that respiratory depression induced by opioids tends to be a short-lived phenomenon, generally occurs only in the opioid-naive patient, and is antagonized by pain.

Therefore, withholding the appropriate use of opioids from a patient who is experiencing pain on the basis of respiratory concerns is unwarranted. Other side effects,

such as constipation, can usually be managed by attention to diet, along with the regular use of stool softeners and laxatives. Sedation and nausea, possible early side effects, usually dissipate with continued use. Depression and confusion, especially in the elderly patient, need to be monitored and treated.

*C. Tolerance:* It was previously thought that the development of analgesic tolerance limited the ability to use opioids efficaciously on a long-term basis for pain management. Tolerance, or decreasing pain relief with the same dosage over time, has not proven to be a prevalent limitation to long-term opioids use. Experience with treating cancer pain has shown that what initially appears to be tolerance is usually progression of the disease. Furthermore, for most opioids, there does not appear to be an arbitrary upper dosage limit, as was previously thought. The use of long-acting opioids may decrease these problems.

*D. Diversion:* Diversion of controlled substances should be a concern of every health professional but efforts to stop diversion should not interfere

with prescribing opioids for pain management. Attention to patterns of prescription requests and the prescribing of opioids as part of an ongoing relationship between a patient and a health care provider can decrease the risk of diversion.

#### **IV. Accepted principles of practice for the prescribing of opioids are needed.**

Due to concerns about regulatory scrutiny, physicians need guidance as to what principles should generally be followed when prescribing opioids for chronic or recurrent pain states. Regulators have also expressed a need for guidelines to help them distinguish legitimate medical practice from questionable practice and to allow them to appropriately concentrate investigative, educational, and disciplinary efforts, while not interfering with legitimate medical care. With this in mind, the State Medical Society of Wisconsin endorses guidelines for prescribing opioids (detailed in Appendix I) and which include evaluation of the patient, development of a treatment plan, consultation with specialists as needed, periodic review of treatment efficacy, improvement in function at home and/or work as appropriate, and documentation of the entire process. Appendix II offers physicians a

patient questionnaire that may help them understand and manage their patient's pain.

#### **V. Physicians who follow principles of practice for the use of opioids, and patients whom they treat, should not be encumbered by inappropriate scrutiny upon their practice.**

Physicians should be able to offer to their patients treatments that are effective, especially when documentation in the medical record demonstrates that benefits outweigh adverse effects in the patient. Patients should not be discriminated against by pharmacy staff or clinic personnel when they are following a rational plan of care that is well-monitored by their treating physician. Patients experiencing the physiologic symptoms and signs of tolerance or withdrawal should not be labeled or stigmatized by medical or nursing personnel. Patients with addictive disorders should not have access blocked to appropriate treatment plans for medical/surgical conditions. And likewise, individuals who manifest substance use disorders after initiation of a plan of care involving opioid therapy, should be referred immediately and efficiently to appropriate professionals to assist them with addictive disease management.

## Appendix I—Guidelines for Prescribing Opioids

The prescribing of opioids, especially chronic administration for noncancerous and nonterminal conditions, should be guided by principles of “best practice,” weighing potential benefits and risks in light of contemporary models and should include the following:

**A. Evaluation:** Any decision to employ opioids in a plan of chronic disease management or

acute pain control begins with a careful, thorough evaluation of the patient which includes:

- a complete medical history
- a history of the pain complaint
- an assessment of the impact of pain on the functional level of the patient
- an assessment of coexisting biomedical conditions
- an assessment of coexisting psychiatric disorders and soci-

ological stressors

- the patient's subjective assessment of his/her own quality of life
- a review of previous diagnostic studies
- a review of previous pharmacologic and non-pharmacologic interventions for the pain complaint
- a history of medications prescribed

- 
- a substance use history
- An opioid trial should not be initiated in the absence of an appropriate assessment of the pain complaint, one which focuses on treatable medical/surgical and psychiatric conditions.**

**B. Treatment Plan:** If chronic opiate use is indicated (daily opiates for greater than 60 days) a treatment plan is ideally documented in the medical record. In formulation of the treatment plan, consideration should be given to both pharmacologic and non-pharmacologic modalities, including behavioral strategies, psychotherapy, coping skills training, relaxation techniques, non-invasive somatic interventions, and involvement with a formal pain rehabilitation program.

It is no longer considered a standard of medical practice to categorically avoid the use of opioids for chronic non-malignant

conditions. However, the potential benefits and risks must be clearly evaluated and explained to the patient. Whenever a trial of opioids is selected, the patient or the patient's guardian should be informed of potential risks, such as sedation, tolerance with chronic use, and withdrawal with abrupt discontinuation after chronic use. With the patient's consent, his/her family or significant other may be similarly informed. Realistic risks about the potential for development of addiction should be reviewed, including education about the differences between physical dependence (the normal, predictable development of tolerance, possible needs for dosage escalation, and withdrawal) and the condition of addiction (loss of control over amounts prescribed, preoccupation, drug hunger, inappropriate medication seeking, or functional impairment due to substance use). The use of a treat-

ment contract, signed by the patient and possibly by the significant other as well, may be considered. Such a contract reviews the conditions under which opioids will be prescribed (e.g., a single prescriber, a single dispensing pharmacy, prohibitions against sharing of the patient's medication with others or the patient's use of another party's medications, responses to misplaced medication supplies, etc.). Patient and family education should emphasize how opioids have a wide margin of safety and efficacy, and should not be irrationally avoided in a treatment plan even though prudent precautions regarding chronic administration are appropriate. Particular challenges are present when a candidate for opioid therapy has an addictive disorder. Patients with opiate dependency are at special risk for experiencing euphoria when opiates are administered in usual dosages, and of developing drug-liking, preoccu-

---

pation, and a rekindling of psychological dependence. Loss of control is a distinct risk with chemically dependent patients. Even patients with alcohol or other non-opioid addiction are at special risk of relapse when opioids are administered. These factors do not constitute an absolute contraindication to the use of opioids when thorough evaluation finds them indicated for such patients; however, consultation with an addiction medicine specialist or certified addiction counselor is essential when anything more than the briefest course of opioid therapy is planned for a patient with a substance dependence disorder. A positive family history of addictive disorder, or a personal history of addiction on long-term stable remission, still are relative indications for consultation with an addiction specialist.

**C. Ongoing Re-evaluation:** As in any case of chronic disease

management, there should be ongoing re-evaluation of the patient, documenting the patient's response to non-pharmacologic and pharmacologic interventions that have comprised the treatment plan. Periodic review of treatment efficacy focuses on the extent to which the treatment plan, in its pharmacologic and non-pharmacologic components, is efficacious in relieving the pain complaint; the extent to which the patient's function level is enhanced by the treatment; the presence of any side effects; any patterns of misuse of medication or dysfunctional obtaining of drug supplies (from friends, other physicians or health care facilities, or illicit sources); and an assessment of the patient's overall quality of life. Periodic re-examination is warranted to assess the status of the pain complaint and to assure that continuation of pharmacotherapy is still indicated. Any decrement

in global functional status should be carefully considered in any long-term plan of care, especially decrements that may be linked to opioid use itself. Whereas development of addiction is rare as a consequence of opioid therapy in individuals with a negative personal and family history of alcohol or other drug dependency, careful and regular screening for addictive disorders or signs of substance misuse is appropriate.

**D. Consultation:** Consultation with specialists in pain medicine, addiction medicine, or mental health should be considered whenever indicated. The treating physician who employs a treatment plan involving chronic opioid use will be well served by documenting the presence or absence of indications for such consultation. Moreover, documentation of periodic reassessment of indications for consultation, can be helpful.



The mission of the *Wisconsin Medical Journal* is to provide a vehicle for professional communication and continuing education of Wisconsin physicians.

The *WMJ* (ISSN 1098-1861) is the official publication of the State Medical Society of Wisconsin and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor is responsible for overseeing the production, business operation and contents of *WMJ*. The editorial board, chaired by the medical editor, solicits and peer reviews all scientific articles; it does not screen public health, socioeconomic or organizational articles. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *WMJ* nor the SMS take responsibility. The *WMJ* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

For reprints of this article contact the *WMJ* Managing Editor at 800.362.9080 or e-mail [wmj@wismed.org](mailto:wmj@wismed.org).

© 2001 State Medical Society of Wisconsin